MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01718

Reg. Dist. No. 1850

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Annie Wilde Anderson

3. (b) Social Security Number: —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Wm. J. Anderson
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): Oct. 3, 1869
8. AGE: Years: 77 Months: 4 Days: — If less than one day: — hrs. — min.
9. Birthplace: Cecil Co. Md. (Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business:
FATHER 12. Name: Geo. C. Magill
13. Birthplace: Ireland
MOTHER 14. Maiden name: Emma Rudy
15. Birthplace: Md.
16. Informant: Richard S. Campbell
Address: 348 S. Morris Av. Crum Lynne Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 6 1947 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace Md.
18. Funeral director: R. Madison Mitchell
Address: Havre de Grace Md.
19. Feb. 5 1947 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 3 1947, at 4:20 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 28 1947 to Feb. 3 1947
and that I last saw her alive on Feb. 3 1947

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to: Chronic Myocarditis	
Due to: Cardiac Decompensation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. L. Lewis M.D. M. D. or other
Address: Havre de Grace, Md. Date signed: Feb-5-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

01719

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 311 Bourton, Lt.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME Harford Baldwin

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elsie Way Baldwin
6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): Oct. 12, 1888

8. AGE: Years	Months	Days	If less than one day
58	3	24	— hrs. — min.

9. Birthplace: Havre de Grace, Md. (Town, county, and state)
10. Usual occupation: Superintendent of Maintenance
11. Industry or business: Havre de Grace Water Co.
FATHER 12. Name: Monroe R. Baldwin
13. Birthplace: Md.
MOTHER 14. Maiden name: R. May Fields
15. Birthplace: Md.
16. Informant: Miss Reta R. Way
Address: Havre de Grace, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 8, 1947 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace Md.
18. Funeral director: R. Madison Mitchell
Address: Havre de Grace Md.
19. Feb. 8 1947 (Date rec'd by registrar) C. T. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 5 1947, at 11:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5 1947, to Feb. 5 1947 and that I last saw h— alive on Feb. 5 1947

Immediate cause of death	DURATION
Arteria Sclerosis	
Due to Coronary Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: Charles J. Foley M.D.
M. D. or other
Address: Havre de Grace Md. Date signed: 2/7/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01720

Reg. Dist. No. 185-0

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred: Harford Memorial Hosp

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Brooks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	M

6.(b) Name of husband or wife: Ella Brooks

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Dec 25 1882

8. AGE:

Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace: Darlington Md (Town, county, and state)

10. Usual occupation: Helper Dentist & Store Help

11. Industry or business

FATHER — 12. Name: Chesley H Brooks

13. Birthplace: Md

MOTHER — 14. Maiden name: Becky Bond

15. Birthplace: Churchville

16. Informant: Mrs Ella Brooks

Address: Bel Air Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feby 16/47 (month) (day) (year)

Cemetery or crematory: Asbury

Location: New Churchville, Md

18. Funeral director: Dean & Foster

Address: Bel Air, Md

19. Feb 13 1947 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 13 1947, at 7.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1947, to Feb 13 1947

and that I last saw h. alive on Feb 13 1947

	DURATION
Immediate cause of death: Congestive Heart failure	4 wks
Due to: Arteriosclerosis CV disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy: Date of operation:

Autopsy results: Pulm Edema & Chr Nephritis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dudley Phillips M.D. M. D. or other

Address: Harford Mem Hosp Date signed: 2/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 01721 / 85-0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred: Harford Mem Hosp

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Herman L. Bushman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife: Unk.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): unk.

8. AGE:

Years	Months	Days	If less than one day
83			..... hrs. ..... min.

9. Birthplace: ? (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER — 12. Name: Unk.

13. Birthplace

MOTHER — 14. Maiden name: ?

15. Birthplace

16. Informant: Harford Memorial Hospital

Address: Havre de Grace Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 1 1943 (month) (day) (year)

Cemetery or crematory: Angel Hill

Location: Havre De Grace Md.

18. Funeral director: R. Madison Mitchell

Address: Havre de Grace Md.

19. Feb 28 1947 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/25 1947, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/23 1947 to 2/25 1947 and that I last saw h.. alive on 2/25 1947

Immediate cause of death	DURATION
Congestive Heart failure	2-3 yr.
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Pleural Effusion - Acute - arteriosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Orville Phillips M.D. M. D. or other

Address: Harford Mem Hosp Date signed 2/26/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7a)

01722

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH:
County: Harford.
City or town: Rural - Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 23 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Rural - Havre de Grace Rt 3
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Level
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward W. Chalk

3.(b) Social Security Number: 212-26-9739

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Roberta P. Gallion

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Sept. 7, 1888

8. AGE: Years: 58 Months: 5 Days: If less than one day: hrs. min.

9. Birthplace: Waterrail, Harford Co., Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Thomas W. Chalk
13. Birthplace: Harford Co. Md

MOTHER
14. Maiden name: Della E. Carty
15. Birthplace: Harford Co. Md

16. Informant: Mrs. Roberta G. Chalk
Address: Havre de Grace - R. F. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 22. 1947 (month) (day) (year)
Cemetery or crematory: Rock Run
Location: Near Darlington, Md

18. Funeral director: Henry Talbert & Sons
Address: Aberdeen Md.

19. Feb. 21 19 47 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION approx

20. DATE OF DEATH: 2-20-47 19 47 at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 19 44 to 2-18-47 19
and that I last saw h. alive on 2-18-47 19

Immediate cause of death: Coronary occlusion

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Havre de Grace Md Date signed 2-21-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-0)

CERTIFICATE OF DEATH

Reg. Diat. No. 1856

1723

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford County
City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford County
City or town: Fallston
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Fallston Road
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME Katherine P. Clark.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Married

6.(b) Name of husband or wife: Winfield Scott Clark
6.(c) If alive, give age: 44 years
7. Birth date of deceased (mo., day, yr.) Dec 29th 1908

8. AGE: Years	Months	Days	If less than one day
38	1	17	hrs. min.

9. Birthplace: Baltimore Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Thomas W. Ryan
13. Birthplace: Balto County Md
MOTHER 14. Maiden name: Mary Katherine Smith
15. Birthplace: Harford County
16. Informant: Winfield Scott Clark
Address: Fallston Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof 2/19/47 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Edmondson Ave Balto Md
18. Funeral director: George J Ruth Inc
Address: 1735 Hanford ave
19. 2-17 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 16 1947 at 5:35 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1924 to Feb 16 1947 and that I last saw her alive on Feb 15 1947

Immediate cause of death	DURATION
Coronary Occlusion	4 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: M D Hopkins M. D. or other
Address: Bel Air Md Date signed: 2/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

★ 01721 Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Forest Hill, Md. R.D. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 87 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Harford
City or town: Forest Hill (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John H. Davis

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widower
6. (b) Name of husband or wife: Dead
6. (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): April 3, 1865
8. AGE: Years: 81 Months: 10 Days: 19 If less than one day: hrs. min.
9. Birthplace: Harford Co., Md (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Housework
FATHER 12. Name: Enos H. Davis
FATHER 13. Birthplace: Chester Co., Penna
MOTHER 14. Maiden name: Elizabeth Amoss
MOTHER 15. Birthplace: Hartford Co., Md.
16. Informant: Mr. Stanley Davis
Address: Forest Hill Md.
17. Burial (Burial, cremation, or removal?) Date thereof Feb. 25 1947 (month) (day) (year)
Cemetery or crematory: Union Chapel Cem
Location: Harford Co., Md.
18. Funeral director: H. S. Bailey
Address: Darlington Md.
19. 2/24 1947 (Date rec'd by registrar) Priscilla Norwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 22 19 47 at 12 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 19 46, to Feb 22 19 47 and that I last saw him alive on Feb 18 19 47

Immediate cause of death: Chr. Lymphatic Leukemia — DURATION: 2

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md Date signed: 2/22/47

1-35

Evidence for change of year of birth shown on Film D.109 - 3/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01725

Reg. Dist. No. 182-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Chestnut Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Rural - Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Chestnut Hill
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Howard Foxwood

3. (b) Social Security Number: No

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: None
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 24, 1870
8. AGE: Years: 70 Months: 0 Days: 15 If less than one day: hrs. min.
9. Birthplace: Harford Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Crops
FATHER 12. Name: Parker Foxwood
13. Birthplace: Harford Co. Md.
MOTHER 14. Maiden name: Julia Smithson
15. Birthplace: Harford Co. Md.
16. Informant: Mrs. Morris Foxwood
Address: Level, Md. R. D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 12 1947 (month) (day) (year)
Cemetery or crematory: Deer Creek Cem.
Location: Chestnut Hill, Harford Co., Md.
18. Funeral director: H. S. Bailey
Address: Darlington, Md.
19. Feb. 10, 47 M. Kirk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9 1947 at 12:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 9 1947, to Feb 9 1947
and that I last saw h- alive on 19
Immediate cause of death: Coronary Thrombosis — DURATION: 20 min
Due to:
Due to:
Other conditions: Chr. Myocardial Disease ?
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill, Md. Date signed: 2/10/47

2-25

2 - 1820 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01726

Reg. Diat. No. 1821

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Harford
City or town Dublin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 79
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Dublin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) Rt
2.(a) If veteran, name war

3.(a) FULL NAME Charles A. Griffith

3.(b) Social Security Number No

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: None
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 18, 1867
8. AGE: Years 79 Months 8 Days 21 If less than one day ..... hrs. ..... min.
9. Birthplace (town, county, and state): Harford Co., Md.
10. Usual occupation: Farmer
11. Industry or business: Crops
FATHER 12. Name: Amos Griffith
FATHER 13. Birthplace: Harford Co., Md.
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace
16. Informant: Mr. Alfred Griffith
Address: Bel-air, Md. R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 11, 1947 (month) (day) (year)
Cemetery or crematory: Dublin Cem
Location: Harford Co., Md.
19. Funeral director: W. L. Bailey
Address: Darlington, Md.
19. Feb 10 1947 (Date rec'd by registrar) M. H. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1947, at 5.30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 4 1947, to February 9 1947 and that I last saw him alive on February 8 1947
Immediate cause of death: cerebral heamorrhage — DURATION
Due to: sclerosis of the arteries.
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE Grayson Dorsey M.D.
M. D., or other
Address CARDIFF Date signed 2-10-47

2-25

2-1120 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

01727

Reg. Dist. No. 180

1. PLACE OF DEATH:
County: Harford
City or town: Magnolia
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Kathryn L. Gunther

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William F. Gunther
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 25, 1876

8. AGE: Years	Months	Days	If less than one day
70	9	26	..... hrs. ..... min.

9. Birthplace: Philadelphia Pa
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John Henry Carroll
13. Birthplace: Essen, Germany

MOTHER
14. Maiden name: Elizabeth B. Rambold
15. Birthplace: Galeston Maryland

16. Informant: William E. Gunther
Address: Magnolia Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 24 1947 (month) (day) (year)
Cemetery or crematory: Cokesbury
Location: Abingdon Maryland

18. Funeral director: Howard K. McCormick
Address: Abingdon Maryland

19. Feb 24 1947 (Date rec'd by registrar) Marie Moakley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 21 1947 at 7:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 28 1947, to Feb 21 1947
and that I last saw her alive on Feb 21 1947

Immediate cause of death	DURATION
Chronic glomerular nephritis	5 yrs
Chronic myocarditis	years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Jed O Hodson M.D.
M. D. or other
Address: Edgewood, Md Date signed 2-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (185-D)

CERTIFICATE OF DEATH

01728

Reg. Dist. No. 185-0

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 4 Weeks.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. Revolution & Juniata
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Earl Gupton

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1/16/47

8. AGE: Years	Months	Days	If less than one day
		28	hrs. min.

9. Birthplace Havre de Grace Md.
(Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name Parland Gupton
13. Birthplace North Carolina
MOTHER 14. Maiden name Rebell Puckett
15. Birthplace North Carolina
16. Informant Mrs. Parland Gupton
Address Revolution & Juniata Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/15/47 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace
18. Funeral director Cunningham & Co
Address Havre de Grace Md.
19. Feb 13 1947 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION Approx

20. DATE OF DEATH Feb. 12 1947, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Accidental Asphyxiation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 2/12/47
Where did injury occur? Havre de grace (City or town) Harford (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury aspiration of Vomitus Injured at work? —

23. SIGNATURE J. D. Ramsey M. D.
Deputy Medical Examiner M.D. or other
Address Aberdeen, Md Date signed 2-15-1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01729

CERTIFICATE OF DEATH

Reg. Dist. No. 1820

1. PLACE OF DEATH:
County: Harford
City or town: Hickory Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Hickory Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James F Herrman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife: Kate E Herrman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 15-1861

8. AGE: Years	Months	Days	If less than one day
85	6	8	hrs. min.

9. Birthplace: Harford Co, Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Wm C Herrman
13. Birthplace: Balto. Co., Md

MOTHER
14. Maiden name: Eliza Holland
15. Birthplace: Harford Co, Md

16. Informant: Roland Hamilton
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feby 26/47 (month) (day) (year)
Cemetery or crematory: Baker's Cemetery
Location: Near Aberdeen, Md
18. Funeral director: Dean & Foster
Address: Bel Air Md

19. 2/24 (Date rec'd by registrar) 1947 Priscilla Fowwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 23 1947, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 15 1946 to Feb 23 1947 and that I last saw h[illegible] alive on Feb 21 1947

Immediate cause of death	DURATION
Chronic Myocarditis	3 yrs
Due to: ~	
Due to: ~	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ~
Date of op.
Autopsy results: ~
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: E. P. Snodgrass M. D. or other
Address: Darlington Md Date signed 2/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-36

01730

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel Air Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3. (a) FULL NAME: George A Howard

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Married

6.(b) Name of husband or wife: Lillian Howard
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): June 11 1900

8. AGE:

Years	Months	Days	If less than one day
46			...hrs. ...min.

9. Birthplace: Bel Air Md (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Grant Howard
13. Birthplace: Md
MOTHER 14. Maiden name: Annie Rice
15. Birthplace: Md
16. Informant: Mrs Lillian Howard
Address: 411 W 125 St apt #30 New York (27)
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 7/47 (month) (day) (year)
Cemetery or crematory: Hanson Hill
Location: Hartford Co Md
18. Funeral director: Deaver Forwood
Address: Bel Air Md
19. 2/5 (Date rec'd by registrar) 1947 Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 5 1947 at 2 40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 1946 to Feb 5 1947
and that I last saw him alive on Feb 3 1947

Immediate cause of death	DURATION
(a) Chr Myocardial Disease	1 yr
Due to	
Due to	
Other conditions Postero-Lateral Sclerosis	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ...Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md Date signed 2/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Z-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (190)

CERTIFICATE OF DEATH

01731

Reg. Dist. No. 1820

1. PLACE OF DEATH:
County: Harford
City or town: Near High Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Near High Point. (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Hubert James

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	D

6.(b) Name of husband or wife ✓
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 11, 1900

8. AGE: Years: 46 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Speedwell, Va
(Town, county, and state)

10. Usual occupation: Farm Labor

11. Industry or business

FATHER
12. Name: J.O. James
13. Birthplace: Va

MOTHER
14. Maiden name: Florence James
15. Birthplace: Va

16. Informant: D B James
Address: Forest Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feby 15/47 (month) (day) (year)
Cemetery or crematory: Groceless Chapel
Location: Speedwell, Va

18. Funeral director: Dean & Foster
Address: Bel Air, Md

19. 2/12 '47 (Date rec'd by registrar) Birrell forward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12 19 47, at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Alcoholism — DURATION
Due to: Exposure to Cold
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. H. Lamey M.D.
Deputy, Medical Examiner
Address: Aberdeen, Md. Date signed 2/12/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

*01732

Reg. Dist. No. 18 10

1. PLACE OF DEATH:
County: Harford
City or town: Perryman
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Perryman
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CARRIE ELIZABETH KENLY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

8.(b) Name of husband or wife
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 11, 1946

8. AGE: Years | Months: 4 | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Havre de Grace, Harford Co. Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Walter Scanlon
13. Birthplace: Perryman

MOTHER
14. Maiden name: Flossie Kenly
15. Birthplace: Perryman

16. Informant: Flossie Kenly
Address: Perryman Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 24 1947 (month) (day) (year)
Cemetery or crematory: Union M.E.
Location: Near Aberdeen, Md.

18. Funeral director: Henry Farring & Sons
Address

19. Feb. 24 1947 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 21 1947, at 11:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death — DURATION

Pneumonia, Broncho, ... 3 days
Malnutrition, Cause .....
Due to .....
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Lamper M. D.
County Medical Exam. M. D. or other
Address: Aberdeen, Md. Date signed: 3/26/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01733

Reg. Dist. No. 162

1. PLACE OF DEATH:
County Harford
City or town Fallston
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Fallston
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William O. Lancaster

3.(b) Social Security Number 214-16 9778

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Edna Lancaster
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1882

8. AGE: Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Farmer and
11. Industry or business Laborer

FATHER
12. Name Wm E. Lancaster
13. Birthplace Maryland

MOTHER
14. Maiden name Isabella Ward
15. Birthplace Maryland

16. Informant Mrs Edna O Lancaster
Address Fallston Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/7/47 (month) (day) (year)
Cemetery or crematory Friendship
Location Fallston Md
18. Funeral director Clair E. Gross
Address Benson Md
19. 2/6 47 Priscilla Townsend
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1947, at 10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 15 1947 to February 4 1947
and that I last saw him alive on January 15 1947

Immediate cause of death Coronary Thrombosis — DURATION: Died Sudden

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE W. Millard Sterling M. D. or other
Address Fallston Md Date signed 2/6/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-m)

CERTIFICATE OF DEATH

★ 01734

Reg. Dist. No. 185-0

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Harford Memorial Hospital
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Leslie Lenoe Lantzy

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	S

6.(b) Name of husband or wife: —
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Feb. 21 1947 - 10 30 P.M.

8. AGE:

Years	Months	Days	If less than one day
0	0	1	12 hrs. — min.

9. Birthplace: Havre de Grace
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Lester Thomas Lantzy
13. Birthplace: Pa.

MOTHER
14. Maiden name: Patricia Mackey
15. Birthplace: Pa.

16. Informant: Sgt. Lester T. Lantzy
Address: 709 Market St. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-24-47 (month) (day) (year)
Cemetery or crematory: Angel Hill Cem
Location: Havre de Grace Md.

18. Funeral director: R. Madison Mitchell
Address: Havre de Grace, Md.

19. Feb-23 19 47 (Date rec'd by registrar) G. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 23 19 47 at 10 30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 21 19 47 to Feb. 23 19 47
and that I last saw her alive on Feb. 23 19 47

Immediate cause of death	DURATION
Shock -	
Due to: Comminute - Compound	
Due to: Fracture - Ventral	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Havre de Grace, Md. Date signed: 2-23-47

VS A15 2-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

01735

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164)

CERTIFICATE OF DEATH

Reg. Dist. No. 18 10

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:
Phila Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Mass. County: Unknown

City or town: Unknown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME WENDELL CHADMAN Mc DONALD

3.(b) Social Security Number 015-07-9150

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1905

8. AGE:

Years	Months	Days	If less than one day
41	4		hrs. min.

9. Birthplace: Mass.
(Town, county, and state)

10. Usual occupation: Unknown.

11. Industry or business

FATHER
12. Name: Stanley "Mc Donald
13. Birthplace: Fredericton, N.B.

MOTHER
14. Maiden name: Ada Ross
15. Birthplace: Bridgetown, N.B.

16. Informant: Next of Kin Certificate

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 18 1947 (month) (day) (year)

Cemetery or crematory: Grove

Location: Aberdeen, Md.

18. Funeral director: Henry Tarring & Sons

Address: Aberdeen

19. Feb. 17 1947 (Date rec'd by registrar) Nellie A. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14, 1947 19..., at 7A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death: Shock and Hemorrhage	
Due to: Gunshot wound of Head	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 2/14/47

Where did injury occur? Aberdeen (City or town) Harford (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: .45 cal Revolver Injured at work? No

23. SIGNATURE: J. H. Ramsey M. D.
Deputy Medical Examiner M.D. or other

Address: Aberdeen, Md. Date signed: 2/15/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01736

Reg. Diat. No. 1830

1. PLACE OF DEATH:

County: Harford

City or town: Darlington (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: md County: Harford

City or town: Darlington (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Isabella Bevard Rampley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: Robert N Rampley 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 18 1859

8. AGE:

Years	Months	Days	If less than one day
88	1	7	hrs. min.

9. Birthplace: Darlington Harford Co Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: James Bevard
13. Birthplace: Darlington md

MOTHER
14. Maiden name: Jemima Street
15. Birthplace: Rocks md

16. Informant: Mrs J. L. Nelson

Address: Darlington md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 28-47 (month) (day) (year)

Cemetery or crematory: Bethel

Location: Madonna Harford Co Md.

18. Funeral director: Martin E Kurtz

Address: Darlington Md.

19. Feb 28 1947 (Date rec'd by registrar) Thomas R Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 25, 1947, at 9 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1946, to Feb 25, 1947 and that I last saw h.r. alive on Feb 24, 1947

Immediate cause of death	DURATION
Heart Failure	8 hrs.
Due to: Hypertensive cardio-vascular disease	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Charles A. Heath M.D. M. D. or other

Address: Street, Md Date signed 2-27-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (110-c)

CERTIFICATE OF DEATH

11737

Reg. Dist. No. 1850

1. PLACE OF DEATH:

County: HARFORD

City or town: HAVRE de GRACE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hours

Hospital, institution, or street address where death occurred: HARFORD MEMORIAL HOSPITAL

How long in hospital or institution? 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: HARFORD

City or town: ABERDEEN - RURAL

(If outside city or town limits, write RURAL and give nearest town)

Street No.: OLD POST ROAD - SWAN CREEK

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME VALLIE H. RUSSELL

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary Russell

6.(c) If alive, give age: Alive years

7. Birth date of deceased (mo., day, yr.): June 10, 1888

8. AGE: Years: 58 Months: 7 Days: 23 If less than one day: hrs. min.

9. Birthplace: Harford Co., Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER

12. Name: Thomas Russell

13. Birthplace: Harford Co., Md

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs. Mary Russell

Address: Havre de Grace Md R.D.

17. Burial (Burial, cremation or removal. Which?) Date thereof: Feb 6, 1947 (month) (day) (year)

Cemetery or crematory: Rock Run Cem

Location: Harford Co., Md.

18. Funeral director: H. S. Bailey

Address: Darlington Md.

19. Feb 5 1947 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEB. 3 1947, at 2:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death

	DURATION
1. RUPTURED DUODENAL ULCER WITH FAT NECROSIS OF PERITONEAL CAVITY.	
2. HEMATOTHORAX - BILATERAL	SMALL
Due to: TRAUMATIC.	
3. FRACTURE OF STERNUM - SIMPLE	
Other conditions: Due to: automobile accident. Cus R.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: AS ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident. Date of: February 1st, 1947.

Where did injury occur? Aberdeen, (City or town) Harford (County) Maryland (State)

Injured at home, farm, industry, public place (where)? Old Post Road & Fenwick Street.

Means of injury: Automobile accident. Injured at work?

23. SIGNATURE: J. F. Lamey M.D.

Deputy Medical Examiner or other

Address: Aberdeen, Md. Date signed: 2/14/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

01738

CERTIFICATE OF DEATH

Reg. Dist. No. 1850

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 hours

Hospital, institution, or street address where death occurred: Harford Memorial Hosp

How long in hospital or institution? 18 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 522 N. Adams St

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Brian Allen Schweers

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 11 - 1944

8. AGE: Years 2 | Months 7 | Days 2 | If less than one day: ... hrs. ... min.

9. Birthplace: Havre de Grace (Town, county, and state)

10. Usual occupation: Child None

11. Industry or business: "

FATHER — 12. Name: Wm. H. Schweers

FATHER — 13. Birthplace: Lancaster Pa.

MOTHER — 14. Maiden name: Elsie Mae Walker

MOTHER — 15. Birthplace: Havre de Grace

16. Informant: Wm. Herman Schweers (Father)

Address: 522 N. Adams St. Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/16/47 (month) (day) (year)

Cemetery or crematory: Angel Hill

Location: Havre de Grace

18. Funeral director: Cunningham & Son

Address: Havre de Grace, Md.

19. 2-14 1947 (Date rec'd by registrar) O. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/13 1947 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/12 1947 to 2/13 1947 and that I last saw him alive on 2/13 1947

Immediate cause of death	DURATION
Peritonitis + Septicemia	18 hrs
Due to: Unknown - possibly	
Due to: Ruptured app	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Dudley Shilling MD M. D. or other

Address: Harford Mem. Hosp. Date signed: 2/13/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

01739

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Churchville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Churchville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Belair Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Anna A. Scott

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Walter F. Scott
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 7, 1886

8. AGE: Years: 60 Months: 6 Days: 5 If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Carl Piene
13. Birthplace: Germany
MOTHER 14. Maiden name: Lizetta
15. Birthplace:
16. Informant: Miss Hilda Scott
Address: Churchville, Md.
17. Burial (Burial, cremation, or removal, which) Date thereof: Feb. 15, 1947 (month) (day) (year)
Cemetery or crematory: St Ignatius
Location: Hickory, Harford Co.
18. Funeral director: H. K. McComas & Son,
Address: Abingdon, Md.
19. Feb 16 19 46 (Date rec'd by registrar) Marie M. Mordsdale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12 19 47, at 12:55 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death: Cerebral Haemorrhage	Momentary
Due to: Hypertensive Cardiovascular Dis.	10 yrs.
Due to:	
Other conditions: Kypho-scoliosis, thoracic spine (Include pregnancy within 3 months of death)	Lifetime

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Peter P. Rodmen M.D.
Address: Aberdeen Md. M.D. or other
Date signed: 2/14/47

Privately Printed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

★ 01740 1821 2

Reg. Dist. No. 1841

1. PLACE OF DEATH:

County: Harford

City or town: Street, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Street, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Henrietta H. Scott

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Samuel L. Scott

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 1 - 1870

8. AGE: Years: 76 Months: 4 Days: 24 If less than one day: ..... hrs. ..... min.

9. Birthplace: Somerset Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: George Howeth
13. Birthplace: Somerset Co. Md.

MOTHER
14. Maiden name: Indiana Miles
15. Birthplace: Somerset Co. Md.

16. Informant: Mrs. Hubert Snodgrass

Address: Street, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 26, 1947 (month) (day) (year)

Cemetery or crematory: Presbyterian cemetery

Location: Pocomoke City, Md.

18. Funeral director: Hubert P. Harkins

Address: Delta, Pa.

19. Feb. 26 1947 (Date rec'd by registrar) M. W. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 24, 1947, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sawhernolyn date of death Feb. 24 1947 and that I last saw her alive on Feb. 24 1947

Immediate cause of death	DURATION
Pulmonary Edema	8 hrs.
Due to Heart failure	2 wks.
Due to Hypertensive Cardio-vascular disease	?
Other conditions None.	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles A. Neff M.D.
M. D. or other

Address: Street, Md. Date signed: 2-24-47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-25

2-1820 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

01741

Reg. Dist. No. 185-O

1. PLACE OF DEATH:
County HARFORD
City or town HAVRE DE GRACE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 MINUTES
Hospital, Institution, or street address where death occurred:
HARFORD MEMORIAL HOSPITAL
How long in hospital or institution? 10 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ben-Del.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Baby Boy Singleton

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 20, 1947

8. AGE:

Years	Months	Days	If less than one day
			hrs. 10 min.

9. Birthplace HAVRE DE GRACE HARFORD MARYLAND
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name GEORGE SINGLETON
13. Birthplace Maryland

MOTHER
14. Maiden name MARY SINGLETON
15. Birthplace CAVALRY MARYLAND

16. Informant George Singleton
Address Aberdeen Md. Gen. Delivery

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/23/47 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace

18. Funeral director Cunningham & Son
Address Havre de Grace Md.

19. 2-21 19 47 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20 19 47, at 10:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-20 19 47, to 2-20 19 47 and that I last saw him alive on 2-20 19 47

Immediate cause of death	DURATION
Premature birth	
Due to Early Delivery	
Due to 5½ months	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE E. J. Simon M. D. or other
Address Havre De Grace Date signed 2-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

A-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93:2)

CERTIFICATE OF DEATH

01742

Reg. Dist. No. 1820

1. PLACE OF DEATH:
County: Harford.
City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mos
Hospital, institution, or street address where death occurred: Fountain Green Hospital
How long in hospital or institution? 9 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bertha Steen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
Female	Wh	Singer

6.(b) Name of husband or ~~wife~~: None
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 20, 1873

8. AGE: Years 73 | Months 9 | Days 19 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pittsburgh Pa
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: John Steen
13. Birthplace: Pittsburgh, Pa

MOTHER
14. Maiden name: Mary McComas
15. Birthplace: Baltimore Md

16. Informant: Wm Bradford
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 12/47 (month) (day) (year)
Cemetery or crematory: Pittsburg Pa
Location: Pittsburg Pa

18. Funeral director: Dean & Foster
Address: Bel Air Md

19. 3/11 19 47 Priscilla Fowwods
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 9th 19 47, at 8:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 19 46, to Feb 9th 19 47
and that I last saw h[illegible] alive on Feb 9 19 47

Immediate cause of death: Hypostatic Pneumonia — Duration: 4 days
Due to:
Due to: malnutrition — 1 yr
Other conditions: Chr Myocardial disease — ?
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson, M. D. or other
Address: Forest Hill Md Date signed: Mar 10-'47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

Evidence for addition of year of birth in Salamonow #109 - 2/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01743

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford

City or town Pleasantville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Harford

City or town Pleasantville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Augusta Townsley.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Chas F Townsley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 9, 1873

8. AGE: Years 73 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Conrad Gunther
13. Birthplace Germany

MOTHER
14. Maiden name Julia Ann Steigle
15. Birthplace Germany

16. Informant Mrs. Marion Townsley
Address Pleasantville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/11/47 (month) (day) (year)

Cemetery or crematory Goodwill

Location Harford Co

18. Funeral director Hamberger & Gross

Address Benson Md

19. 2/10 1947 P Forword
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8th 1947, at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1 1942 to Feb 8 1947 and that I last saw her alive on Feb 7 1947

Immediate cause of death	DURATION
Coronary Thrombosis	7 da
Due to	
Due to	
Due to	
Other conditions Chr. Essential Hyper-tension (Include pregnancy within 3 months of death)	10 yr

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Willard P Hudson
M. D. or other

Address Forest Hill Md. Date signed 2-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

01744

CERTIFICATE OF DEATH

Reg. Dist. No. 183 O

1. PLACE OF DEATH:
County: Harford
City or town: Upper X Roads
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Rural - Fallston
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Celia Margaret Wagner.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: James I. Wagner
6.(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): June 24, 1865

8. AGE: Years	Months	Days	If less than one day
81	7	11	....hrs. ....min.

9. Birthplace: Stoney Fork, N.C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: George Watson
13. Birthplace: Wilkes Co. N.C.
MOTHER 14. Maiden name: Keziah Mophew
15. Birthplace: Ash Co. N.C.
16. Informant: James I. Wagner
Address: Baldwin, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 9, 1947 (month) (day) (year)
Cemetery or crematory: Upper X Roads Baptist
Location: Upper X Roads, Har. Co. Md.
18. Funeral director: Martin G. Kurtz
Address: Jarrettsville, Md.
19. 2/8/47 (Date rec'd by registrar) 19.... Thomas Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 5 19.47, at 10.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 19.47, to Feb 6 19.47 and that I last saw h.. alive on Feb 5 19.47

Immediate cause of death	DURATION
Ch. Myocardial Disease	
Due to	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard R. Hudson M. D. or other
Address: Forest Hill Md. Date signed 2/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

FILED APR 14 1947 CERTIFICATE OF DEATH

01745

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Harford

City or town Forest Hill (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life Rural. Harford Co

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Harford

City or town Forest Hill (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Florence Virginia Wilgis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife John W. Wilgis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 4 - 1854

8. AGE: Years	Months	Days	If less than one day
92			..... hrs. ..... min.

9. Birthplace Emmorton, Md
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Charles Watters

13. Birthplace Md

MOTHER 14. Maiden name Ellen Magness

15. Birthplace Md

16. Informant Mr Herman S. Wilgis

Address Forest Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 15/47 (month) (day) (year)

Cemetery or crematory Mt Zion

Location Fountain Green Md

18. Funeral director Dean & Foster

Address Bel Air Md

19. 2/14 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1947, at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 - 1947, to Feb 13 1947 and that I last saw her alive on Feb 11 1947

Immediate cause of death	DURATION
(a) Chr Myocardial Disease	7
Terminal Hypostatic Pneumonia	3 da
Due to	
Due to Accidental fall — fell to floor from bed. Cerebral	
Other conditions Fracture of hip	6 wks.

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of January 10th, 1947.

Where did injury occur? Mr. Forest Hill, Harford, Maryland.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At home.

Means of injury Accidental fall. Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other

Address Forest Hill Md Date signed 2/14/47

1-35